Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE GARLAND

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-14-3122-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 12, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached dates of service, 02/24/2014, 02/19/2014, 03/21/2013, 01/17/2013, 06/28/2012, 06/22/2012 and 11/30/2012 has been denied due to 'WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT." Per ODG Office Visits are medically necessary for the Evaluation and Management to determined proper diagnosis and return to function of an injured workers. The Code that is being billed is per the Medicare Fee Schedule. There has been numerous attempts to reach the adjuster to confirm and clarify this denial but I can never get a response. All others bill have been paid and then payment stopped (SEE ATTACHED). Patient was not released to return to work til 03/17/2014 so I don't understand why additional benefits have not been paid or given adequate explanation for non payment. I have resubmitted this request to the carrier and they are still denying payment."

Amount in Dispute: $869.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 22, 2012 June 28, 2012 November 30, 2012 January 17, 2013 March 21, 2013 February 19, 2014 February 24, 2014	CPT Code 99213-25 Office Visit	$114.25 $114.25 $114.25 $118.83 $119.22 $114.45 $114.45	$0.00
June 22, 2012 June 28, 2012 January 17, 2013 February 24, 2014	CPT Code 99080-73 Work Status Report	$15.00/each	$0.00
TOTAL		$869.70	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
4. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1-Workers' Compensation jurisdictional fee schedule adjustment.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. Does the documentation support billing of CPT code 99213?
3. Does the documentation support billing of work status report in accordance with 28 Texas Administrative Code §129.5?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of services in dispute are June 22, 2012 through February 24, 2014. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on June 12, 2012. This date is later than one year after the date(s) of service June 22, 2012 through March 21, 2013. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section for dates of service June 22, 2012 through March 21, 2013; consequently, the requestor has waived the right to medical fee dispute resolution for these dates.

2. On February 19 and 24, 2014, the requestor billed CPT code 99213.

   CPT code 99213 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   A review of the submitted medical reports does not support billing of CPT code 99213. As a result, reimbursement is not recommended.

3. On February 24, 2014, the requestor billed CPT code 99080-73.

   CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

   28 Texas Administrative Code §134.204 (l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

28 Texas Administrative Code §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

28 Texas Administrative Code §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report:
(1) after the initial examination of the employee, regardless of the employee's work status;

(2) when the employee experiences a change in work status or a substantial change in activity restrictions."

The requestor submitted copies of the January 1, 2013 and February 24, 2014 report that does not support a change in the claimant's work status or a substantial change in activity restrictions to support billing in accordance with 28 Texas Administrative Code §129.5 (d)(1) and(2); therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/03/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.